Department of Health and Human Services
Health Care Financing Administration
Operational Policy Letter #94
OPL99.094

Date: May 11, 1999

Subject: Updating of the "Medicare Managed Care National Marketing Guide"[1]

Issue/Question: Corrections and Clarifications to Marketing Policy

A. Definition of a Medicare+Choice (M+C) Provider Sponsored Organization (PSO)

M+C PSO means a M+C organization (M+CO) that has received a waiver from HCFA of the M+C State licensure requirement in accordance with 42 CFR 422.370-.378, and has met the definition of a PSO at 42 CFR 422.350-.356 through an approved M+C contract application.

Background

Sections 1851(a)(2)(A) and 1855(d) of the Balanced Budget Act of 1997 (BBA) and implementing regulations at 42 CFR 422.350-.356, create and define "plans offered by provider sponsored organizations" as an option for Medicare beneficiaries. Because the BBA and implementing regulations provide a very precise definition of this M+C PSO option, we believe it is necessary to ensure that only M+COs that meet this definition identify themselves as a "M+C PSO" or imply that they are one of the specific PSO options for Medicare beneficiaries defined by the BBA and implementing regulations under M+C.

We also believe that limiting the term "M+C PSO" to M+COs operating under a waiver of the M+C State licensure requirement is the best way to ensure that only M+COs that meet the PSO definition are identified as M+C PSOs, since this provides a consistent distinction between M+C PSOs and other M+COs. M+C PSOs will be different in three tangible ways. First, they will have received a waiver from HCFA to operate without a State license for 36 months. Second, they will have had their organizational and health service delivery structures evaluated by HCFA to verify that they meet the M+C PSO definition. And third, they will have met Federal solvency standards developed specifically for PSOs operating without a State license.

We considered allowing State licensed M+COs to identify themselves as "M+C PSOs," if HCFA could determine that these entities met the M+C PSO definition. However, we

[1] This represents the third OPL update to the National Marketing Guide. The first two updates were: OPL 97.060 [revised] dated July 20, 1998 and OPL 99.079 dated February 4, 1999.

believe that this could lead to confusion about the M+C PSO option because it does not provide adequate consistency and a proper distinction between Federally regulated and State licensed PSOs. Since organizational and health service delivery structures are constantly changing, a State licensed PSO's M+C PSO status could change several times as it falls in and out of compliance with the Federal PSO regulation definition. In addition, we do not believe that HCFA should use its resources to monitor the compliance of State licensed organizations with the M+C PSO definition, if there is not a clear value in doing so.

Marketing Guidelines

A M+CO may only identify itself as an "M+C PSO" or imply that it is one of the PSO options for Medicare beneficiaries under M+C, if it has received a State licensure waiver from HCFA in accordance with 42 CFR 422.370-.378. State licensed M+COs may identify themselves in marketing materials as a "Provider Sponsored Organization (PSO)", a "State licensed PSO with a M+C contract", or any other term generally applied to managed care organizations that are sponsored by health care providers as long as they do not use the specific term "M+C PSO" or imply that they are one of the specific PSO options for Medicare beneficiaries defined by the BBA and implementing regulations at 42 CFR 422.350-.356.

B. Employer Group Health Fairs

Chapter II - Promotional Activities, Section B. "Health Fairs and Health Promotional Events," page 11, after second bullet add third bullet, which reads as follows:

"Employer Group Health Fairs"

The enrollment restrictions found on page 10, last bullet, and page 11, first bullet, (i.e., no sales presentations can be made or enrollment applications accepted at the meeting) do not apply to health fairs or other promotional events sponsored by an employer group or labor organization so long as the following restrictions are met:

1. The meeting must be held solely for retirees or those soon to retire (and their spouses/interested decision makers) from the employer/labor organization. No "general public" persons may be solicited or invited to attend the meeting.

2. The meeting may not be announced via "public media" vehicles. Potential employer group/labor organization retirees must be notified of the meeting by individual notification or by company/labor organization sponsored media such as a newsletter or similar targeted mailing/vehicle.

C. Provider Promotional Activities

In Chapter IV - Provider Promotional Activities - make the following two corrections:

1. Correct item 1 under **Provider Marketing** to read as follows:

   "Provider groups and individual providers can give out health plan brochures (exclusive of applications) at a health fair or in their own offices. Brochures and posters announcing plan affiliation are also permitted in provider offices. The providers or their representatives cannot compare benefits among health plans or take applications at health fairs. (See B. Health Fairs and Health Promotion Events section at the end of Chapter II - Promotional Activities - of this Guide). This is because they may not be fully aware of all health plan benefits and costs. Providers, their representatives and qualified plan (marketing) representatives are all prohibited from taking applications in provider offices or other places where health care is delivered. This is to prevent Medicare beneficiaries from experiencing inappropriate pressure to enroll at the time health care is being delivered."

2. Correct item 4 under **Provider Marketing** to read as follows:

   "Provider groups can furnish a complete list of Original fee-for-service Medicare patients to an M+CO. The list should not disclose specific Medicare entitlement information (month/year of entitlement to Parts A/B; or source of entitlement - age/disability). The list should not provide information that might be used in health screening (age; or health status). This is because their interests in promoting one plan over another may not always mirror the beneficiary's interest and providers may not always be fully aware of all membership health plan benefits and costs. Additionally, providers and provider groups are prohibited from furnishing anyone information that identifies a particular enrollee where the source of the information came through election of a M+CO plan, and where the information is being furnished for a non-plan purpose."

D. Model Evidence of Coverage (EOC)

The Model EOC that first appeared in August 1997 as Chapter VI of the Marketing Guide was replaced by a Model M+CO EOC dated October 22, 1998. The Model M+CO EOC is currently undergoing revision. Until the new Model M+CO EOC is completed, the following corrections need to be made to it:

1. In Section 5, You Can Change Primary Care Physicians, *delete the following*:

   "The [name of M+C Plan] will review your request to change to a different Contracting Medical Group or IPA on a case-by-case basis. We may deny your request if:

- you are an inpatient in a Hospital, a Skilled Nursing Facility or other medical institution at the time of your request;

- the change could have an adverse affect on the quality of your health care;

- you are an organ transplant candidate; or

- you have an unstable, acute medical condition for which you are receiving active medical care."

Under 42 CFR 422.112(a)(2) and QISMC standard 2.2.3.1 and, an M+CO enrollee has the right to select a new PCP from those accepting Medicare members. The right cannot be denied for any reason.

2. Throughout the Model M+CO EOC, wherever a telephone number is provided to call the M+CO's Customer Service number, a reference to the "TTY/TDD telephone number for the hearing impaired" must also be provided. The M+CO may reference the TTY/TDD relay number, if one is available in the market area.

3. Please note that Section 2 - Eligibility, Enrollment and Effective Date - of the Model M+CO EOC does not include a reference to hospice election being a reason for denial of enrollment in a M+CO plan. Individuals who have elected Medicare's hospice coverage cannot be denied membership in a M+CO plan.

E. Updated Enrollment and Disenrollment Member Notices

HCFA's Center for Beneficiary Services is updating Chapter 3 of the M+C Manual. The CBS update will include new model enrollment, disenrollment and other member notices. This update to Chapter 3 of the M+C Manual will appear on HCFA's Home Page at www.HCFA.gov on the Internet very soon. The new model notices will completely replace the current Chapter V of the Guide entitled, "Model Enrollment, Denial of Enrollment and Disenrollment Letters."

F. Partial Monthly Open Enrollment

At the end of Chapter III - Sales Packages and Advertising - in the Marketing Language: Must Use/Can't Use/Can Use Chart, update the row on Limited Open Enrollment Period as follows:

- In the Must Use column add: "Describe open enrollment period, if open enrollment is for 'partial month' only. MEDIA: All except outdoor. Outdoor advertising has the option of excluding this topic."

- In the Reason column add: "If a plan will be closed for the last several days of every month, the plan needs to inform prospective enrollees that election forms received by the plan after a specific date every month will not result in enrollment

until the first day of the second calendar month following the month in which the plan receives the election form."

G. Products and Services to Encourage Compliance with Preventive Health Practices

These products are considered to be in the contracted plan benefit package (ACRP and BIF/PBP) under "Preventive Services." Generally, the provision of such incentives are within the purview of the medical management philosophy of the M+CO and do not require additional review by HCFA for marketing accuracy/compliance.

H. Use of Ethnicity or Religious Affiliation in Plan Names

M+COs are permitted to use ethnic and religious affiliation in their plan names, as long as the legal entity to which the plan belongs has a similar proper name/affiliation. For instance, if a plan is affiliated with the Swedish Hospital of Minnesota, it would be permissible for the plan to use the tag line, "Swedish Plan, offered by Swedish Hospital System of Minnesota."

I. Availability of TTY/TDD Communication for the Hearing Impaired

This is a reminder that M+COs must inform members and potential enrollees of the availability of TTY/TDD communication with the plan.

- In the model member notices soon to be released by HCFA's Center for Beneficiary Services, whenever a plan telephone number is referenced for further communication with the plan, a TTY/TDD number will also be required. (item E above)

- In the Model M+CO EOC we are currently updating, all chapters and sections will now say that whenever a plan telephone number is referenced for further communication with the plan or plan providers, a TTY/TDD number will also be required "for the hearing impaired." (item D above)

- On the last page of the "Must Use/Can't Use/Can Use" chart in the Marketing Guide HCFA currently requires all plans to indicate that a telecommunication device for the deaf (TDD/TTY) is available to get additional information or to set up a meeting with a sales representative.

Contact: HCFA Regional Office Managed Care Staff

This OPL was prepared by the Center for Health Plans and Providers